RANNEY (G.E.) ad

# INAUGURAL ADDRESS

ON

# OBSTETRICS AND GYNECOLOGY

DELIVERED BEFORE THE

**Michigan State Medical Society,**

BY

GEO. E. RANNEY, M. D.,

LANSING,

Hon. Member of the Mich. State Med. Soc.; Corresponding Member of the Detroit Medical and Library Ass'n; Hon. Member of the Pere Marquette Med. Soc.; Member of the American Med. Ass'n; Member of the British Med. Ass'n; Member of the British Gynecological Ass'n; Etc., Etc.,

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# ANNUAL ADDRESS BEFORE THE SECTION ON OBSTETRICS AND GYNECOLOGY.

GEO. E. RANNEY, M. D., CHAIRMAN OF SECTION,
Lansing.

*Ladies and Gentlemen:*

According to custom, and according to the order of business arranged by our executive committee, it becomes my duty to occupy your attention at this time; but with due regard for your patience and my own unfitness, I shall not burden you with an exhaustive, retrospective, advisory discourse, nor shall I attempt the difficult and extensive task of reconciling the conflicting views and expressions of opinion concerning the many questions now on trial and which have been and are now being discussed in the journals, monograms and societies devoted to this rapidly advancing branch of medical knowledge.

To submit to close analysis the whole range of the new and modifications of the older methods of obstetrical and gynecological treatment, and to scrutinize their manifold relations and define their respective merits, is a task calculated to appall a busy practitioner and unpretending writer.

But it is well that at times men powerful in language and potent with pen, review, more fully than I shall attempt to do, the literature and practice of the day in certain branches—men who sift the wheat from the chaff, forcibly commend the many new and valuable theories demanding our recognition, and with equal force invoke censure upon the erroneous, yet fashionable, fleeting and evanescent, practices of the day.

With no facile element of display, be mine the less laborious task of alluding, though in a somewhat cursory way, to a few of the practical (therefore, more important) principles of treatment which should engage the careful attention of the general practitioner, and upon the systematic knowledge of which, in many cases, may hang the issues of life and death, of disease and

long suffering, of enervated vital energies, invalidism, and a weakened, exhausted constitution, which, if not destructive in its effects, renders women less able to resist disease to which they may be predisposed from hereditary tendencies and unfavorable environments.

It may not be expected that, as a rule, the general practitioner will be able to cope with the many causes of pelvic troubles now made possible by surgery, but by a careful study of their pathology, and the prevention which thorough antisepsis affords, he should be able not only to prevent many, but to understand the condition which gives rise to others—such as the numerous reflex symptoms that uterine diseases produce,—and, at least, recommend the proper treatment, without subjecting them to unsuccessful, and therefore harmful, medication.

*Trachelorrhaphy.*—Emmet's operation is no longer an experiment, nor the conditions requiring it obscure or difficult, as a rule, to recognize. Yet, how many women (perhaps reluctant to submit to the proper examination) go the rounds of medical treatment, and, after years of suffering and despondency, under the positive advice of able gynecologists are informed for the first time of the real seat of their disease. How many such women, suffering from hysteria, epilepsy, uterine paralysis, headache, menstrual trouble, disturbed vision, severe cough, lung disease, mental irritability, and other innumerable functional disturbances, have finally been, under skillful advice and treatment, restored to health by this safe, and by no means severe, operation. In Europe, at least in London and Berlin, it is not as popular as in this country, but in that I think we are in advance.

I spent November and December, 1886, in the Woman's Hospital of London, and saw nearly every operation made there during that time, without seeing Emmet's operation performed once during that period. I spent October of the same year in Dr. Martin's hospital, in Berlin, during which time the operation was not performed in that institution. Dr. Martin, however, frequently amputates a portion of the cervix, and by that means, I have no doubt, accomplishes nearly the same good effects that Emmet's operation would; for, by the opera-

tion, the cicatricial tissue, which is, no doubt, a great source of irritation, is removed, and the revulsive effect and involution follow, probably, as in the former, and, as I believe, better, operation. In cases of subinvolution and extensive disease of the endometrium, Martin curretts the womb at the same sitting that he amputates its neck, and, maybe, performs Hagar's operation on the perineum. I have often curretted the womb, made Emmet's operation on the cervix, and Hagar's on the perineum, at the same sitting. Notwithstanding all the fear that has been expressed concerning the use of the curette, I believe, with proper antiseptic precautions, in those cases where the womb is patulous, or following rapid dilatation of the womb, the operation is comparatively safe; at least, it has been so in my hands. I should have great dread of the operation, however, following the use of tents.

Dr. Reamy says: "Emmet's operation for restoration of the cervix to normal conditions in cases where a manifest fissure exists, is, in my opinion, warranted upon the sole ground of prophylaxis against malignant disease, if upon no other."*

It is held by some, and I am very much inclined to the belief, that fissure of the cervix commonly exists before, and is the secondary, if not the direct and only, cause of epithelioma of the cervix.

*Perineorraphy.*—Laceration of the perineum is often overlooked by the obstetrician and puerperum, and, if they do not omit to see and recognize the rent, regard it trivial and neglect the necessary steps to repair the injury. It is not uncommon to hear physicians say that they have never seen, in a somewhat extensive practice of midwifery, a lacerated perineum. It was but a few years ago that such a physician, writing for a medical journal, in his attempt at ridicule, said that it was coming to such a pass with a certain class of physicians who regarded perineal ruptures so common, that ere long they would be advocating the necessity of going armed with needle and thread to every case of confinement, in order that they might be ready to stitch up a laceration. It is safe to say that he who does not go so prepared, and he who ridicules such

*Reamy's Annual Address, Trans. Am. Gynecological Soc., 1886, p. 55.

practice, does not watch the presenting parts of the fœtus, or subsequently inspect the perineum, and, very likely, neglects the antiseptic precautions made especially necessary by the laceration which he does not suspect.

To be sure, we may not always be able to recognize a perineal rupture by inspection alone. There may be no surface wound, as the laceration may occur submembraneously; but by grasping the rupture between the finger and thumb, it will be found that the perineal body is gone and nothing interposes but the membranes. The remote sufferings that such accidents incur, saying nothing of the immediate dangers of septisemia, burning pain in standing, walking or sitting, and especially in micturition, are many and severe. It is not uncommon for women with long neglected, cicatrized perineal rent, broken in health, despondent, and with an apparently bankrupt constitution, to consult us, never suspecting the cause of their malady, but who, because of a lacerated perineum, to use Dieffenback's expression, "are ashamed of themselves, even as a woman who has been castrated."

On examination, we find the *rama pudendi* gaping posteriorly, and the anterior vaginal wall gaping, and a diseased, enlarged, displaced womb, and the patient suffering from manifold reflex disturbances unnecessary to enumerate to members of this Section.

Emmet says "That reflex irritation does emanate from the perineum as the effect of a local exciting cause, cannot be questioned. The presence of sympathetic nerves offers an explanation of the reflex irritation so often produced by the cicatricial tissue in the perineum;" and I think he might add that branches of the sympathetic and the pelvic and spermatic plexi, not involved in the cicatrix, but pressed upon by an enlarged, retroverted or retroflexed womb, play an important part in these remote sympathetic effects. As to whether the perineum and vagina support and assist in holding the womb in place, or whether, as claimed by some, it has no more to do with it than the diaphragm in supporting the heart and lungs, or the intestinal tube in holding the stomach in place, I shall not argue here. It is a significant fact, however, in my observations, at least,

that in cases of rupture involving the whole perineal body and a portion of the gut, the descent of the womb has been less than in cases following partial perineal rupture. This is well accounted for in a paper by Dr. S. T. Donaldson, published in the Archives of Gynecology, and referred to in the *Journal of the British Gynecological Society*, 1887, p. 223, in which he says that complete rupture of the perineum has not the same amount of influence in producing prolapse as a partial tear has, for the reason that in complete lacerations the septum between rectum and vagina is done away with entirely, whereas in partial rupture the septum remains, only much thinned. This septum is gradually stretched by the lodgment of fæces and intra-rectal pressure, which bulges out the septum, causing a rectocele to form. As the rectocele becomes more and more marked, the septum drags on the cervix, and so pulls the uterus out from the "dome of the sacrum" downwards and forwards. This displacement of the uterus from under the sacrum brings it into the vaginal axis and allows intra-abdominal pressure to come into play, thus causing the uterus to gravitate still further in the vaginal canal. The mischief begins with the loss of fascial tension at and around the seat of lesion. Gradually, other neighboring tissues become involved, until, finally, remote ones are implicated. When rectocele does not hasten the process, the tissues at the lower end of the vagina are affected, and the retro-pubic segment descends, so that a cystocele forms and so drags down the uterus.

Perinorraphy extending high up the vagina, or, what is better, Hagar's operation, will generally overcome the prolapse of the womb; also the rectocele and cystocele, though in severe cases I sometimes make a separate operation for the cystocele at the same sitting.

*Alexander's Operation.*—Shortening the round ligaments for uterine displacement, first performed December 14, 1881, by Dr. William Alexander, has of late received considerable attention by gynecologists, both in this country and in Europe. It is claimed by its author that the operation is not an obstacle to pregnancy or parturition.

Dr. J. Mathews Duncan, Dr. Clement Godson, and Prof. W. S. Playfair, of London, speak disparagingly of the operation, and Prof. Wallace, of Liverpool, actually condemns it.

*Per contra*, Dr. Halliday Croon, of Edinburgh, Dr. John E. Burton, of Liverpool, and James A. Adams, of Glasgow, and others, speak favorably of it.

That the womb may, for a time, at least, be held perfectly in place by the operation, I do not doubt; and I am equally sure that in selecting the appropriate cases to operate upon, the best skill of the surgeon is shown.

It is claimed, with a very good show of experimental proof, that the main supports of the uterus are the elastic, sub-peritoneal, pelvic fascia and the utero-sacral ligaments; also the lateral, to a small degree; and that the round ligaments do not act as such. With these facts in view, I would not expect that the suspension of the fundus uteri to the anterior abdominal wall by shortening the round ligaments, would be of permanent value, without correcting the conditions which cause the prolapse and flexion. At least, with a lacerated perineum and a relaxed floor of the pelvis, and their usual accompaniments, I believe the operation would result in no permanent good; for the cords would soon relax, from the constant pressure brought to bear, in the way mentioned above (in speaking of the production of the rectocele and cystocele), and the displacement become as great as before.

I would reserve Alexander's operation for those cases of displacement of the womb not held by adhesions, and not amenable to perinorraphy or the revulsive effects of trachelorrhaphy and curetting, and properly adjusted pessaries.

*The Curette.*—The use of the curette, I believe, is in more general favor than formerly. In chronic endometritis and subinvolution of the uterus and consequent sterility, I believe it of the greatest value.

If the new theory of Dr. Johnston, of Lexington, Ky., endorsed by Mr. Lawson Tait* and others, is correct, that menstruation is the result of glandular function, and that the menstrual organ is the endometrium, "we have an explanation," as

*British Medical Journal, January 22, 1887.

Mr. Tait says, "of a most intrinsic physiological and pathological difficulty, the riddles of which seem to be wholly beyond our grasp.

"First of all, we have an explanation of the familiar fact, that impregnation and menstruation seem to have a clear relation as to coincidence, the plain fact being that an impregnated ovum adheres only on a surface denuded of epithelium. When desquamative salpingitis has destroyed the tubal epithelium, the ovum may be impregnated in the tube, and may adhere to the exposed corpuscular tissue, and the dreadful issue of tubal impregnation will result."

We all know sterility is the common result of chronic endometritis. If the obstruction be removed by the curette, and, as a consequence, a healthy glandular development of the endometrium takes place, sterility will be thereby often overcome.

*The Uterine Sound.*—The sound, formerly so much vaunted as an instrument of diagnosis, should be avoided, except as a final diagnostic resort; for serious results too often follow its use, especially in the hands of the careless or inexperienced.

*The Use and Abuse of Pessaries.*—Some tacitly affirm that pessaries are an abomination, and, while they do no good, often produce harm. Now, I believe that he who cannot use a pessary without doing harm, should, of course, abandon its use, but he should not criticise those better qualified than himself. The one who thinks lightly of their use and speaks with derision of their utility, I take it, shows only that he cannot appreciate what he cannot understand. Common sense teaches us that a broken bone or dislocated joint may require a support; and it seems equally rational that a dislocated uterus may be benefited by a properly adjusted pessary. To be sure, if the womb is bound down by inflammatory adhesions, a forcible attempt to replace it with pessary or other means, may result in the gravest consequences, by setting up peri-uterine inflammation or by pressing upon a prolapsed ovary, producing intolerable pain. But, after depleting the displaced and inflamed womb by ordinary means, the pessary, though to be avoided if such means will suffice, may be of great importance in lifting

the womb from the great sacral plexus, or from its pressing upon the rectum or bladder, and by overcoming the obstruction to the venous circulation.

*Signs of Pregnancy.*—Dr. Reamy says: "Our manifest inability to detect early pregnancy is the opprobrium of obstetrics;" and adds, "Is it not probable that nature hangs out, somewhere, an unequivocal sign of this most important event in the animal economy, early in its career?"

There is a great diversity of opinion among obstetricians as to the value of certain signs, which diversity may be the result of accident or a want of a careful study and an accurate recognition of those signs. Hagar's sign, which consists in the uterus losing its pear-shaped outline, the body being bellied out over the cervix in all the transverse diameters, especially antero-posteriorly, is looked upon by Drs. Grandin, Reiul and Mitchell, of England, as almost an infallible sign.

Jacquemier, in 1876, called attention to a bluish coloration of the vagina, as an almost unmistakable sign of pregnancy, after the fourth week or subsequent to the time the woman would have menstruated were she not pregnant. The coloration is described as of a blue or deep violet hue of the vaginal mucous membrane. The color is sometimes compared to dregs of wine. To this color, together with the œdematous, velvet-like feel of the rounded os and an increased secretion of the mucous membrane, I attach great weight. To inspect the coloration of the vagina, the use of the speculum is deemed necessary by some, but, in most cases, it is, I believe, most plainly marked at the *introitus vaginæ*, particularly just around and beneath the urethral orifice, and can be readily seen by parting the labia with the fingers. The coloration is supposed to be caused by an interruption of circulation through the venous plexus, and also the same may occur from hemorrhoids or from uterine fibroma, the truth or falsity of which may be a factor in differential diagnosis. Dr. Robert Barnes says, "The most valuable sign of all is the violet coloration of the vaginal portion and the vagina described by Jacquemier." Dr. James B. Chadwick, of Boston, says: "In scrutinizing the color of this part in a large number of women, I early discovered that,

while in a majority a bluish tinge appeared over the whole vaginal entrance, there was a fair proportion in which the violet tint was confined to the anterior wall of the vagina, just below the urinary meatus, where it shaded off into the normal pink color laterally. This, when distinctly perceptible, is soon found to be, in my practice, an absolutely sure sign of pregnancy. There were, furthermore, a very few in whom the blue tint was universal, but more accentuated on the posterior wall of the vaginal entrance, which I found was valueless as a sign of pregnancy unless the color was quite deep. The recognition of this peculiar localization of the blue tint on the anterior wall as a sure sign of pregnancy, I feel is the most important new point in this communication." *

*Electricity.*—As a therapeutic agent, electricity has been going up and down, and the laudations of many of its enthusiastic advocates have only been equaled in earnestness by its opponents, who believe that it doeth no good and thinketh no good. Disrepute, no doubt, has been brought upon it by a class of practitioners, who with just ability enough to turn a crank or set the machine going, have made for it the most extravagant claims. They are those who "keep the word of promise to our ear, and break it to our hope."

Recently, under a more scientific, systematic study of the therapeutical effects of this mystic force, especially under the lead of Apostoli, at least in gynecological practice, it has assumed quite a prominence, and is looked upon with favor by many of our ablest gynecologists, who have studied the proper indications for its use and the way to use it to meet the requirements of special cases, and proportioning the dose required as regards quantity and intensity, the choice of faradic or galvanic current, the proper choice of poles, localization, duration of sittings, proper electrodes, etc.

Dr. George J. Engelman,† of St. Louis, says that he has obtained excellent results by the use of electricity in the treatment of neoplasms of various kinds, such as fibroids, polypi, cystic growths, urethral carbuncles and hemorrhoidal tumors,

* Transactions of the American Gynecological Society, 1886, p. 407.

†Transactions of the American Gynecological Society, 1886, p. 251.

also in chronic ovarian inflammation, stenosis of uterine canal, sub-involution, prolapsus uteri, menorrhagia, chorea, etc.

In the treatment of fibroma of the uterus by Apostoli's recent method, electricity has attracted, as a therapeutic agent, more attention than heretofore, and with a show of favor that bids fair to place it among the most reliable, if it does not establish it as the most potent remedy in such cases.

But the growth of myoma seldom or never commences before puberty, and its growth ends with the climacteric, if it does not actually lessen or undergo spontaneous degeneration; hence, under any mode of treatment, either by the ergot or Apostili's method, the most satisfactory results may be reported, while the improvement may have been the result of causes independent of treatment.

Dr. Robert Barnes says, in his work on Diseases of Women: "A fibroid tumor, being like in constitution to the uterine muscular wall, and growing in it and depending upon it for its existence and nutrition, may be expected to follow closely the conditions of its parent organ. Accordingly, it grows during pregnancy, and undergoes retrogression or involution when pregnancy is over; and, sometimes, involution, being thus started, passes into atrophy, and the tumor disappears altogether. *Thus pregnancy* may cure fibroid tumors. The process, no doubt, is *fatty degeneration*, the same as that which melts away the muscular tissue of the uterus. *The fatty transformation of fibroids is very common.*"

Prof. Winkle reports a case of spontaneous degeneration of a fibroid, which came under his notice, and says: "One must, in accounting for this, think of the fatty degeneration of the smooth muscular fibres of, and absorption of the degenerated parts, the same as occurs in the uterus after childbirth."

Löhlein, of Berlin, reports, in the *Zeitschrift fuer Geburtshuelfe und Gynaekologie*, Vol. 1, 1877, eighteen cases of spontaneous cure of uterine fibroids, and says that he has no doubt that fibroids are much more frequently a complication of pregnancy than is supposed, and their disappearance after confinement is more common than is generally recognized by the profession.

The late Prof. Schräder, of Berlin, reports thirty-six cases of uterine fibroids, in which pregnancy occurred, and found the tumors to disappear in six cases.

Nouss, of Halle, in Hospital Report, 1872, reports eighteen cases of pregnancy occurring co-existing with fibroma, six of which tumors disappeared, and in two others but very small evidences of the tumors could be found.

Lawson Tait, in his work on Gynecology, reports one case coming under his notice.

Dr. Lee, in his work on Clinical Midwifery, says that "Sometimes the tumor disintegrates or undergoes atrophy, and disappears wholly or in part, after labor, or, at least, to such an extent as to escape detection. Dr. Ragan reported a striking case in which a tumor was mistaken for a second child. The woman recovering, the tumor rapidly disappeared below the pubes. She had observed the same phenomena in preceding pregnancies. Dr. Leonard Sedgwick relates (St. Thomas' Hospital Reports, 1870) two cases in which uterine tumors entirely disappeared after delivery. Montgomery cites similar cases." A most important feature occasionally attending this complication is the extreme difficulty in establishing a correct diagnosis. There is no certain means in some of these cases of diagnosing between fibroma, fibro-cystic, uterine tumors, and cases of either complicated with pregnancy.

I have said enough by way of establishing the comparatively frequent occurrence of the spontaneous degeneration of uterine fibroids, but might quote many other authors to that purpose, besides my personal observation and verbal reports from obstetricians.

I have thus digressed to show that, either by the use of electricity or other treatment, fibroid tumors lessen or disappear, and that care should be taken not to "filch from Nature's good name," by arrogating to ourselves the credit of the use of potent means of cure, which is really brought about by natural causes.

In attempting to impress the important lesson of the self-limitation and spontaneous degeneration of uterine fibroid tumors, I wish not to disparage the honorable place that elec-

trotherapy has, under the guidance of Apostoli, taken in gynecological practice.

In the few instances I have employed electrolysis in the treatment of fibroids, I have obtained almost uniformly good results; and the statistics of Apostoli, as well as the favorable reports of its use by such men as Engelman, of St. Louis, Munde and McGinnis, of New York, Martin, of Chicago, and others, are convincing proofs, to my mind, that it will hold respectable rank with the knife as a means of cure of uterine fibroma.

Dr. Thomas Keith reports having treated successfully, in five months, 100 uterine fibroid tumors by electrolysis, and says: "So strongly do I now feel on this subject, that I should consider myself guilty of a criminal act were I to advise my patient to run the risk of her life—and such a risk—before having given a fair trial to this treatment."

*Antisepsis.*—Antiseptic practice in midwifery has resulted in a sudden fall in mortality of puerperal women; and the diseases incident to septicæmic poisoning, such as puerperal fever, cellulitis, phlegmasia dolens, etc., are conditions that justly raise the question of neglect, carelessness or ignorance, on the part of the accoucheur. *"The name of Lister is, at one step, made the greatest in the practice of midwifery, his discoveries having achieved more for the comfort and safety of lying-in women than the combined efforts of succeeding generations of enthusiastic obstetricians."

In my practice of midwifery during the past twenty years I have been in the habit of insisting upon a thorough and frequent cleansing of the genital tract of my lying-in patients with hot water sterilized with carbolic acid or bichloride, one part to three thousand, and of lessening the absorbing surfaces by closing lacerations as far as possible. In doing this, for a large part of that period, at least, I "builded better than I knew," for, while I practiced this as a matter of cleanliness, to assist normal involution of the uterus, and to render the patient more comfortable, I did not recognize the importance of its antisepsis, which has, during the last few years, been known to

*Mathews Duncan.

be so marvelous in the prevention of puerperal disease. Doing a fair amount of obstetrical practice during my professional career in civil practice (now over twenty-two years), it has been my fortune to lose but one patient of my own from childbirth or its after effects; and I attribute no little of this good fortune to as thorough antiseptic treatment as is practicable in a general practice. No one who has studied the matter can doubt that antiseptic treatment has done marvels in lessening the death rate of puerperal women, and the terrible results of septic complications following confinement which were formerly so common in such cases. No greater duty, it seems to me, in the light of the revelations of the antiseptic treatment of puerperal women, can fall to our lot than to combat, by means of antisepsis, this terrible scourge incident to child-bearing. Yet, I fear that the antiseptic midwifery is not generally practiced as we would have a right to expect, and according to the light we have concerning this universally recognized principle, the details of which, as to a thorough contraction of the womb and expulsion of clots, antiseptic solutions and dressings for physician and nurse, pure air, and all the means to prevent the septicæmic poison being conveyed to the patient, the limits of this paper will not permit me to discuss.

Dr. W. S. Playfair, of London, in presenting the proofs of safety that antisepsis afford the lying-in women in hospitals, which were formerly hot-beds of death and disease, says that they are rendered as safe, or safer, than in a large and luxurious private house, with competent nurse and physician, and all that money can procure, and adds:

"There is nothing in the history of medicine more remarkable than the change which has come over the working of these public institutions since Lister's life-saving principle has been adopted. There the battle is gained. I doubt if such a thing can be found as a lying-in hospital in which rigid antisepsis is not the rule."

He says, however, that he very much questions if even yet antiseptic midwifery is at all in general use in private practice, for, as consultant, he seldom finds that practitioners in attend-

ance followed any of the antiseptic rules which are universally so rigidly enforced in lying-in hospitals

In preparing the original notes and headings for this paper, I found that to amplify them all would extend the communication beyond its reasonable limits, and would include some points which would be more appropriate for a paper with a more definite title than appears in the index to this address. Therefore, under the title, "Treatment of Mastitis and Galactorrhœa by Pressure," I have written a paper which, with your permission, I will present later during this meeting.

In touching upon the many important themes of this address, I have tried to give hints, gleams and rays of medical truth of practical utility, only discussing such subjects as the general practitioner should be familiar with, without subjecting himself to the danger of becoming lop-sided by his devotion to a specialty.